PRINTED: 08/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		475245	B. WING			С		
175245					710.0005	08/27/2013		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP CODE			
GOLDEN LIVINGCENTER - EDWARDSVILLE				751 BLAKE ST. EDWARDSVILLE, KS 66111				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000				
F 371 SS=F	complaint investigation 483.35(i) FOOD PROSTORE/PREPARE/S The facility must -	SERVE - SANITARY	F	371				
	considered satisfacto authorities; and	n sources approved or ory by Federal, State or local stribute and serve food ions						
	by: The facility census to residents received for Based on observation	otaled 93 residents and 93 od from one main kitchen. n, interview, and record led to store, prepare and litary conditions.						
	_	e kitchen on 8/23/13 at 10:00 llowing in the walk-in						
	container with severa of lunch meat. 2) Half of an onion ur wrap lying on bear sh	ned undated lunch meat in a all other unopened packages and atted wrapped in plastic nelf. bag of uncooked chicken						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	_	TITLE			(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
						С		
175245			B. WING	B. WING			08/27/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EDWARDSVILLE				7	STREET ADDRESS, CITY, STATE, ZIP CODE '51 BLAKE ST. EDWARDSVILLE, KS 66111			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE		
F 371	egg containers onto a The following observed 1) A opened undated chips. 2) One opened undated 3) On a open counter of steak with a piece of the steak. 4) One and half donur piece of paper lying a 5) Under a small sink particles and a dried be shelves when opened 6) Three drawers condebris on the frame of particles inside each of 7) Ice chest sitting on contained melted wat inner rim. 8) A serving cart with debris on the shelves outside of the cart. 9) A serving cart that 4 trays contained food outside of the cart and the handle well. 10) Ice machine with the inside of the mach 11) A wire rack that conted with greasy lint. 12) The back of the contained greasy lint. 13) A electrical cord be covered with greasy lint.	dripping down the side of a shelf. ed in the kitchen area: half bag of semi-chocolate ed loaf of bread. a paper plate with a piece of paper wrap lying across as on a paper plate with a cross the donuts. observed dried food brown liquid spot on the lathe sliding doors. It in the sliding doors. It in the drawer and food drawer. a rolling cart which er and debris around the lathe sliding doors around the lathe sliding doors. It is in the drawer and food drawer. In a rolling cart which er and debris around the lathe shelves contained food and dried drips on the lather shelp water glasses on the lather the local spots on the lather shelp water glasses on the lather shelp water gla	F	371				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		175245	B. WING	B. WING		08/27/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - EDWARDSVILLE				75	TREET ADDRESS, CITY, STATE, ZIP CODE 51 BLAKE ST. DWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			
F 371	The following observed 1) The floor under the area of build up slimy 2) The garbage disposiblack substance on the substance of the substance o	op lying on top of a greasy, ining thickener powder. ed in the dishwasher room: e garbage disposable with an a substance. esable covered with greasy ne top. ained the water booster unable to be cleaned. machine with cover off and elf and the entire unit dirt. Inperature log for the month peratures for all shifts up to th. solicy "Cleaning Schedules" tive cleaning schedule must sted for each piece of eas that require routine service department. solicy "Storing Prepared the director of dining or the that all food is properly sed of according to M. dietary staff A chen needed cleaned better. ed no previous months vailable due to staff not	F	371			

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175245 B. WING 08/27/2013	(X3) DATE SURVEY COMPLETED	
00/2/12013	I	
NAME OF PROVIDED OF CURRULED	08/27/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	BE COMPLETION	
F 371 Continued From page 3 resided in the facility.		